

LETTER TO THE EDITOR

Response to S. Leonard Syme's Essay

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To the Editor:

The essay "Social Determinants of Health: The Community as an Empowered Partner" by Dr S. Leonard Syme addresses why, in spite of all the biomedical advances and clinical interventions, most clinical studies are designed simply to assess disease and not to assess disease in people, especially those at the bottom of a social structure.

At the National Institutes of Health (NIH), where I have worked as a chemist for the last 20 years, it is a time of great expectations, tremendous growth, and a newfound enthusiasm under a newly proposed NIH roadmap, which holds the promise of translating basic research discoveries from bench to bedside. However, in my African American west Baltimore neighborhood, where I have resided for more than 20 years, that same air of promise and expectation for healthier lifestyles at the hands of current biomedical research does not exist. In fact, changing the face of biomedical research is not high on the list of most people's daily priorities.

Two Saturdays ago, as I was leaving a drug store in my neighborhood, I was privy to a conversation between two elderly black women, one of whom had either just picked up or dropped off a prescription. The very brief yet insightful exchange, in my opinion, sums up the sentiment many African Americans like myself have about today's health care system and health care providers. One lady commented to the other, "You know, I have a young doctor now and he's prescribed this new medication — just experi-

menting on me." The other lady responded, "Yes, indeed, that's all they're doing — just experimenting." This conversation exemplifies the lack of trust that still exists among African Americans, old as well as young, with health care and health care research.

To rid our country of the health disparities that still exist, first and foremost we must regain the trust of people most affected by health care disparity. Although these ladies may not have a clue about biomedical research, they realize that in spite of their efforts to establish good health regimes, widely accepted interventions might not resolve their health problems. As suggested by Dr Syme, we will achieve this trust only when researchers realize that people are the most valued resource in biomedical research and are humble enough to admit it.

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To the Editor:

The recent essay by Dr Leonard Syme contributes constructively to the dialogue on disparities (1). It validates the idea that the traditional focus on the individual and risk factors is limited and underscores the importance of environment and community. The complexity of community, however, is not apparent in the essay, and this oversight adds to deficiencies in interventions. Public health needs a different paradigm for assessment and intervention development.

One barrier mentioned by Dr Syme is arrogance, and to that I would add elitism; both prevent experts from relating and adopting paradigms that use community as the unit of analysis. Both challenge diversity and inclusivity, which are necessary for community partnerships. Also troublesome is a limited definition of competency. Dr Syme illustrates the ineffectiveness of interventions in several studies. Others have outlined limitations in addressing community: McKenzie (2) (on the impact of racism and community), Vena and Weiner (3) (on the social determinants of health and community), and Richards, Kennedy, and Krulewitch (4) (on evaluation models that insufficiently encompass community complexity).

Dr Syme uses environment as a metaphor for community, but environmental change is safe verbiage that disguises the limitations of theory and practice. Environmental change factors are merely risk factors writ large. They are reductionist, failing to build a comprehensive understanding of community and reinforcing tradi-

tional analyses, which assess outcomes in terms of etiology or predictive factors. They do not assess relationship to community but impose it. Because risk factors relate to individual well-being, we often incorrectly assume they relate to community outcomes.

Dr Syme also uses social status as a metaphor for community. The construct is simple: draw a circle around an entity and name it community. Indeed, Dr Syme defines as community any group that is targeted: citizens of Richmond, Calif, fifth-graders, bus drivers. Each possesses an ethos and a consciousness, but each also lacks the complexity of community. The most critical mistake in targeting a social stratum is creating the illusion that we are targeting a community. We design an intervention for welfare mothers, for example, and write up our findings as a community intervention. But targeting the poor is not the same thing as targeting the community. Change theory derives from the individual unit of analysis and from constructs that do not reflect the complexity inherent in communities.

Another flaw in Dr Syme's essay is the exclusion of race/ethnicity. This exclusion is compounded by insufficiency of community theory and practice and emphasis on etiology and risk factors. Multivariate analysis suggests variables that are important based on statistical significance. Education and income knock race/ethnicity "out of the box." This exclusion is incorrect. Etiology assumes a core role in developing interventions. This may make sense when the unit of analysis is the individual, but it is unfounded when the target is the community.

Communities defined by race/ethnicity magnify the error. Although poverty is the predictive variable, poor people tend not to live in integrated communities. The social reality of imposed segregation is ignored. Indeed, observations of an area of homelessness in Los Angeles

showed that white, black, and Latinos each reside on separate street corners (5).

We must develop interventions at 2 levels: by identifying causal factors and deciding at what depth the intervention is to occur and by relating the causal factors to the target population. What do causal factors mean to the population? What is the best protocol for delivery? Superimposing the community over the multivariate analysis is a paradigm shift from traditional biostatistical training, and we need to explore it.

The challenge for the 21st century is to develop theory and practice that resonate with community and its determinants: history, culture, context, and geography. Community competence, a protocol for intervention development, is one solution (6). It avoids the reductionism inherent in cultural competency, and is enhanced by language, literacy, positive imagery, salient imagery, multiple generations, and diversity.

Progress in public health science and practice throughout the 20th century reflects our understanding of the individual. While progress in environmental health has been obvious, progress within race/ethnic communities is not so evident. Upgrading our sanitation and related regulatory protocols benefited populations defined by geography and work site. African Americans and Native Americans continue to demonstrate disparities. Ethnic communities within Latino and Asian/Pacific Islander aggregations demonstrate similar disparities. Why? Our science and practice fails to assess community trends or develop tailored interventions. The 21st century should be the "century of the community," and the emphasis of efforts to improve theory and practice ought to reflect this paradigm.

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References

1. Syme L. Social determinants of health: the community as an empowered partner. *Preventing Chronic Disease* [serial online] 2004 Jan [cited 10 Feb 2004]. Available from: URL: http://www.cdc.gov/pcd/issues/2004/jan/03_0001.htm.
2. McKenzie K. Racism and health: antiracism is an important health issue. *BMJ* 2003 Jan 11;326:65-6.
3. Vena JE, Weiner, JM. Innovative multidisciplinary research in environmental epidemiology: the challenges and needs. *Int J Occup Med Environ Health* 1999;12 (4):353-70.
4. Richards L, Kennedy PH, Krulewitch CJ, Wingrove B, Katz K, Wesley B, et al. (2002). Achieving success in poor urban minority community-based research: strategies for implementing community-based research within an urban minority population. *Health Promotion Practice* 2002;3 (3):410-20.
5. LeDuff C. Skid row still down on its luck. *International Herald Tribune* 2003 Jul 15:5.
6. Robinson RG. Community development model for public health applications: overview of a model to eliminate population disparities. *Journal of Health Education Practice*. Forthcoming.